Natural Healing Through the Laws of Health
Lifestyle Assessment
By
PTH Ministries & Home Health Education Services

"Knowing that if you have the faith of a mustard seed, your faith can move mountains"

CONFIDENTIAL

IMPORTANT

Please Note: The health information received during this consultation is for general education and is not intended to be specific medical advice. No medical care, diagnosis, or treatment is provided during this consultation. It is advisable to consult with ones personal health care provider before implementing any lifestyle changes.

I release Home Health Education Services Online Inc., Lifestyle counselors or associated organizations from any and all liability. Participation in this consultation indicates acceptance of these terms.

Signature: _____ Date: _____

General Information

Name: _____

Address: _____

Telephone: Home (___) _____ Work: (_____) _____

Cell: (___) _____ Email Address: _____

Church Affiliation: _____ How long have you been a member? _____

List any health concerns you have: (physical, mental, social or spiritual): _____

_____
_____
_____

When did you last consult a physician? _____

Are you currently being treated for any ailments? Yes / No

If yes, which ones?

_____
_____

Please list any surgery that you have had (along with the date):

_____
_____

What diseases have you been diagnosed with? (please list all)

_____
_____

Are you presently experiencing any of the following: (please circle)

Dizziness	Numbness	Bad body odor
Fainting	Clammy skin	Excessive sweating
Nausea	Cold hands or feet	Hair loss
Pain	Constipation	Fever
Heart palpitations	Diarrhea	Infections
Fatigue	Indigestion / Acid Reflux	Bleeding
Headaches	Cold / Flu	Weight loss
Memory loss	Blurred vision	Weight gain
Insomnia	Swelling anywhere	Sexual dysfunction
Difficulty breathing	Parasites / Worms	Anemia

Do you suffer from any of the following emotional / mental disorders: (please circle)

Depression	Chronic anxiety	Bipolar
Co-dependency	Manias	Schizophrenia
Phobias	Obsessive compulsive disorder	Neurosis

What specific condition(s) would you like this consultation to address?

_____
_____
_____

Age: ____ yrs.

Sex: (Circle one) Male Female

Marital Status – (circle) Single, Married (1st / 2nd / 3rd or more), Divorced (1st /2nd or more), Widowed married (1st,2nd, 3rd) widowed divorced

How long have you been married or divorced _____

Weight: _____ lbs. Height: _____ Sedimentation Rate: _____

Blood Pressure: ____/____ Pulse _____

Glucose: _____ Postprandial (2 hours after meal): _____

Cholesterol: _____ HDL: ___ LDL: ____ Triglycerides _____

Please list all medicines or pills you are currently taking:

_____
_____
_____.

Please list all supplements and / or herbs that you are taking (vitamins, minerals, nutritional drinks etc…)

_____
_____

Nutrition

Circle One where needed

1. Do you eat any meat or flesh items (chicken, turkey, pork, fish, shrimp etc…)? Yes / No ☐
2. Do you eat any dairy items or eggs (i.e. milk, cheese, yogurt, chocolate etc…)? Yes / No ☐
3. Which ones?
   _____
4. Do you eat refined white products (i.e. white bread, white rice, white flour products, etc…)? Yes / No ☐
5. How many servings of fruit per day? ____ How many servings of vegetables? ____
6. Do you use condiments (i.e. ketchup, mustard, mayonnaise, barbeque sauces, veggienaise, nayonaise, salad dressings, pickles, vinegar, etc…)? Yes / No ☐

7. Do you add any of the following spices to your foods: cinnamon, nutmeg, cloves, curry, hot sauces, and cayenne peppers, black and white peppers and etc? Yes / No

8. Do you eat fried foods? Yes / No If so, how often? _____

9. Do you use margarine or butter? Yes / No If so, how often? _____

10. Do you use baking powder or baking soda? Yes / No

11. Do you eat fresh bread? (bread eaten less than 48 hours after baking) Yes / No / Sometimes

12. Do you eat or drink any cocoa, chocolate or ice cream? Yes / No How often? _____

13. Which oils do you cook with? _____

14. Do you read the labels of food items that you buy from the store? Yes / No

15. List any sweeteners you consume (i.e. sugar, honey, splenda, sweet & low, equal or additional artificial sweeteners, etc…)
_____

16. How much & often do you eat nuts? _____ Which ones?
_____

17. Do you eat any canned items (beans, veggies, fruits, veggie meats etc…)? Yes / No

18. Which ones? _____

19. Are you on any special diet? Yes / No

20. If so, please list: _____

21. Do you eat out? Yes / No If so how often: _____

22. Do you use salt? Yes / No Does the salt contain iodine? Yes / No

Exercise

1. Do you exercise? Yes / No

2. How many times per week? _____ How many minutes per day? _____

3. How would you rate your exercise? (circle one) Mild Moderate Vigorous

4. What are your favorite exercise sessions?
_____

5. How do you feel after you exercise?
_____

6. Do you experience any pain while you are exercising? Yes? No

Water

1. How many glasses of water do you usually drink per day? _____

2. What kind of water do you commonly drink?
_____

3. Is your water filtered? Yes / No

4. At what temperature do you drink your water? (circle one) Hot Cold Room temp.

5. Do you eat ice? Yes / No

6. How many glasses of juice do you drink per day? ____

7. How many cans / bottles of soda per day? _____

8. What other liquid do you drink (i.e. tea, wine, alcohol, beer, soda, milk, vitamin water, etc…)?

_____

9. Do you drink with your meals? Yes / No / Sometimes

10. What color is your urine normally? (clear, pale, slight yellow, yellow and dark yellow)

Sunlight

1. How much sun exposure do you get per day? _____

2. Do you sunbathe? Yes / No If so how long? _____

3. Do you wear short sleeves? Yes / No

4. Do you use sun block? Yes / No / Sometimes

5. Do you have any abnormal sensitivity to the sun naturally or due to any medications? Yes / No

6. Do you take vitamin D supplements? Yes / No

7. Do you have any family history of skin cancer? Yes / No

Temperance

1. What is your current occupation? _____

2. Please list your last five jobs and the years of service: _____
_____
_____
_____
_____
_____

3. Do you smoke / use tobacco products in any form (i.e. chewing tobacco)? Yes / No

4. Did you use tobacco in the past? Yes / No If so how much and for how long? _____

5. Do you use alcohol in any form? Yes / No If so, how much and for how long? _____

6. Do you ingest caffeine in any form? Yes / No (e.g. coffee, teas, mate, colas, energy drinks, etc.)

7. If so, please list _____.

8. Do you overeat? Yes / No / Sometimes

9. Do you eat too fast? Yes / No / Sometimes

10. Do you chew your food thoroughly? Yes / No

11. Do you snack between meals? (this includes any food items and juice) Yes / No / Sometimes

12. List any desserts you eat? (include candies, cakes, or pies)
    _____

13. Do you eat at set meal times? Yes / No

14. Please list times for all meals: Breakfast _____ Lunch _____ Supper _____

15. Would you say that your dress is healthful and modest? Yes / No

16. Please list your leisure activities (i.e. watching TV, reading, sports, dancing, board games etc…)
    _____

17. How much time do you spend on leisure activities? _____

18. Do you overwork? Yes / No / Sometimes

19. Please list any addictions
    _____

20. Have you been involved with substance abuse? Yes / No If so please list: _____

21. Do you read novels, science fiction, pornography, fashion magazines, computer games? Yes / No

22. If so, which ones? _____

23. Do you attend cinemas, dances, night clubs, house parties and amusement parks? Yes / No

24. If so, which ones? _____

25. Do you play any competitive sports? Yes / No

26. If so, what sports are they? _____

27. Please list all types of music that you listen to?
    _____

Air

1. Where do you live? (Circle one) City Suburbs Country
2. Do you sleep with your windows open? Yes / No
3. Do you open your windows / doors daily to air out the home? Yes / No
4. Do you live or work in a smoke-filled environment? Yes / No
5. Do you have any smokers living in your home? Yes / No
6. Do you have live plants throughout your home? Yes / No
7. Are there any environments that you are in that do not have a good supply of fresh air? Yes / No
8. If so what are they? _____
9. Do you wear tight fitted clothing that restricts your lung expansion? Yes / No

Rest

1. What is your usual bedtime? _____
2. Do you wake up during the night? Yes / No / Sometimes
3. Do you snack before you go to bed? Yes / No / Sometimes
4. Do you sleep with the lights on? Yes / No / Sometimes
5. Do you work the night shift or swing shift? Yes / No / Sometimes
6. Do you wake up early in the morning and find it difficult to get back to sleep? Yes / No / Sometimes
7. Do you take sleeping pills? Yes / No
8. Do you make it a practice to get to bed at a certain time? Yes / No
9. Do you rest from labor at least one day per week? Yes / No

Trust

1. Do you have a daily devotional time? Yes / No

2. If no, would you like to have one? Yes / No

3. Do you spend time reading the Bible daily? _____

4. Do you return a faithful systematic tithe, plus offerings? Yes / No

5. Do you have difficulty in trusting the Lord with your problems? Yes / No / Sometimes

6. Do you suffer any remorse, guilt, worry or fear at present? Yes / No

7. Do you believe that you have experienced the forgiveness of God in your life? Yes / No

8. Do you struggle with knowing God's will for your life? Yes / No

9. Would you consider your family to have good relations with each other? Yes / No

10. Do you have a spiritually strong immediate family? Yes / No?

11. Do you have peace with God and your fellow men? Yes / No

12. Have you broken any vows or promises to God that is within your power to fulfill? Yes / No

13. How has the Lord been treating you? _____

14. How have you been treating the Lord? _____

15. If the Lord were too come today, knowing the life that you are currently living, would you be saved? Yes / No ***"Please answer this question within yourself."***

LIFESTYLE RECCOMENDATION

MORNING DEVOTION	***EVENING DEVOTION***
Start with prayer	***Start with prayer***
Sing a few hymns	***Sing a few hymns***
Read a devotional book	***Do your lesson study***
Read the conflict of the ages health message	***Study***
1. Patriarchs and Prophets Pathways	***1.***
2. Prophets and Kings and Foods	***2. Diet***
3. Desire of Ages Counsels Health	***3.***
4. Acts of Apostles Temperance	***4.***
5. Great Controversy	***5. Health books***

<u>God Cares series</u> ***Close with a word of prayer***

1. Daniel
2. Revelation

Close with a word of prayer

Ps: please read the scriptures when studying the conflict of the ages.

Daily Schedule

Time to get up: _____

Time for worship: _____

Time for exercise: _____

Time for breakfast: _____

Time for digestion walk: _____

Time for lunch: _____

Time for digestive walk: _____

Time for Supper: _____

Time for digestive walk: _____

Time for evening worship: _____

Time for rest: _____

Special notes:

Sample Meal 1

I. Fruit: 3-5 servings

II. Whole Grain Cereal sweetened w/ Fruit 1 cup servings

- 2 Tablespoon of flax seed freshly grounded can be sprinkled over cereal at breakfast.
- ¼ cup of pumpkin seed can be eaten with the breakfast cereal.

III. 1-2 slice of whole grain bread with natural almond.

- Other natural healthy spreads/butter is acceptable as well. (i.e. Tahini, cashew)

Sample Meal 2

I. Salad and/ or Vegetables ½ of the plate

II. Grains ¼ of the plate

- Grains consist of starches (i.e. brown rice, baked potatoes, whole wheat pasta.)

III. Nut or Bean Loaf ¼ of the plate

Recipes for nut, grain and bean loaves can be found in the following cookbooks: Tasty Vegan Delight, Seven Secrets, The Optimal Diet, and Foods with their Healing Power vol. 3.

Dinner

PASS ON DINNER.

If third meal is required, a few fruits or a slice or two of toasted whole grain bread with 100% fruit spread can be eaten. No nut butters should be used.